400 CASE MANAGEMENT

401 Overview

This chapter defines the role of the DES/DDD Support Coordinator (formerly known as the Case Manager) and provides a summary of the Support Coordinator's responsibilities for coordinating service provision to persons with developmental disabilities.

402 Role of the Support Coordinator

Case Management is defined in A.R.S. § 36-551(6) as the process of "coordinating the assistance needed by persons with developmental disabilities and their families in order to ensure that persons with developmental disabilities attain their maximum potential for independence, productivity and integration into the community." Case Management is known as Support Coordination.

Case Manager is defined in A.R.S. § 36-551(7) as the "person who coordinates the implementation of the individual program plan of goals, objectives and appropriate services for persons with developmental disabilities." Case Managers are known as Support Coordinators.

The Arizona Long Term Care System (ALTCS) Program Management Manual further defines Case Management as the process through which appropriate and cost effective medical and medically-related remedial services are identified, planned, obtained and monitored for individuals eligible for ALTCS services. ALTCS specifies that the purpose of Support Coordination is to ensure that ALTCS eligible individuals obtain medically necessary services in a cost effective manner. Each person eligible for ALTCS must receive Support Coordination services.

The Support Coordination role can be divided into six general functions:

<u>Intake and Eligibility Determination:</u>

This function involves the process of accepting applications for services from DES/DDD, making recommendations as to whether the applicant meets DES/DDD's eligibility criteria and assisting DDD eligible persons to apply for services from the Arizona Long Term Care System (ALTCS).

Policies and procedures for this eligibility determination are described in Chapter 500 of this Manual.

Assessment:

Assessment is the process by which the Support Coordinator, in conjunction with the Individual Support Plan (ISP) team, gathers and evaluates information in order to assist the individual/family/responsible person to determine the individual's goals, outcomes, supports and services needed. This function begins at intake and occurs concurrently with other functions throughout the Support Coordination cycle. Assessment is described further in Chapters 700 and 800 of this Manual.

Plan Development:

This function involves the process by which the Support Coordinator facilitates an interdisciplinary team to develop the ISP. The ISP is a person centered plan of care which identifies needed goals, outcomes, supports and services and directs the provision of those supports and services. Chapter 800 of this Manual details the policies and procedures necessary to complete this function.

Plan Coordination:

This function includes activities necessary to obtain the supports and services identified in the ISP such as referral within and outside the agency, prior authorization, completion of cost effectiveness studies, waiting list activities and interaction with health plans and other agencies. Plan coordination requirements are outlined in Chapter 900 of this Manual.

Plan Monitoring:

Plan monitoring is the process by which the Support Coordinator ensures that the individual receives quality supports and services in a cost effective manner as outlined in the ISP, progresses toward identified goals and outcomes and receives quality supports and services in accordance with DES/DDD's Mission and Value Statement. Chapter 1000 of this Manual describes specific responsibilities for accomplishing the monitoring function.

Case Closure:

When services provided by the agency are no longer needed or appropriate or the individual voluntarily withdraws, the Support Coordinator is responsible for completing case closure activities, as outlined in Chapter 1100 of this Manual.

In order to complete these functions, the Support Coordinator must listen, in an objective manner, to the needs and preferences of the individual/family and help the individual/family to translate those needs into the language of the various systems with which the person/family interacts. The Support Coordinator must have a thorough knowledge of the many and varied systems which have an impact on an individual/family and be able to assist and advocate for the individual/family to access these systems and services in a cost effective manner. The goal is to assist the individual to function as independently as possible in the least restrictive appropriate setting as determined in the ISP, within the constraints of limited appropriations and statutory and regulatory requirements.

403 Responsibilities of the Support Coordinator

The DES/DDD Support Coordinator is responsible for:

a. accepting referrals for potential applicants; scheduling and conducting intake interviews; obtaining information and documentation necessary to determine eligibility; comparing the documentation to Division eligibility criteria; screening newly eligible DDD individuals for potential ALTCS or Targeted Support Coordination eligibility and referring those individuals to AHCCCS and completing related documentation. In some Districts, these responsibilities may be assigned to a limited number of Support Coordinators who specialize in the intake process (Chapter 500);

b. developing a thorough understanding of the programs and services operated by other local, State and federal agencies; ensuring these resources are used when appropriate and coordinating services between and among the varied agencies so that the services provided by DES/DDD for an individual complement, but do not

duplicate, services provided by the other agencies (Chapters 300 and 900);

c. developing a thorough understanding of the services funded by DES/DDD and ensuring these services are utilized in accordance with the parameters defined in this Manual (Chapter 600);

d. interviewing the individual/responsible person and, if appropriate, the family; completing and/or reviewing various assessments or evaluations, and facilitating the synthesis of all information necessary to identify existing potential and needed supports and to determine the individual's need for service (Chapter 700);

e. scheduling and facilitating ISP team meetings; writing and distributing the ISP document to the individual/family and all team members; and reviewing the ISP at specified intervals (Chapter 800);

f. obtaining prior authorization for DES/DDD funded services, if required, as indicated in Chapter 900; coordinating with Managed Care Operations (MCO) for persons who are medically involved, completing documentation necessary to refer individuals for DES/DDD funded services; completing Cost Effectiveness Studies and Waiting List activities if necessary; referring individuals/families as appropriate to other agencies; completing coordination activities specified in Inter Governmental Agreements and Interagency Service Agreements; participating in discharge planning activities if required; assisting the ALTCS and Targeted Support Coordination eligible individual/family to enroll in a Health Plan, choose a Primary Care Physician (PCP), and receive acute care services as needed; and other activities necessary to ensure the individual is linked with services and resources identified in the ISP (Chapter 900);

g. conducting and documenting ISP reviews at specified intervals; monitoring and following up to ensure delivery of quality services; and ensuring that services are provided in a safe manner, in full consideration of the individual's rights (Chapters 1000, 1500, and 1700);

h. completing eligibility termination activities when necessary (Chapter 1100);

i. ensuring that safeguards are implemented to plan and account for expenditures from the person's financial resources for individuals for whom DES/DDD is representative payee and/or who receive services in residential settings operated or financially supported by DES/DDD (Chapter 1300);

j. completing additional required Support Coordination responsibilities as necessary for children in foster care, persons served by the ventilator dependent program, and/or persons served by the Medicaid behavioral health program (Chapter 1400);

k. ensuring that the ISP is developed, implemented, and monitored in accordance with A.A.C. R6-6-9 for individuals receiving behavior modifying medications or in need of other interventions to manage inappropriate behavior (Chapter 1600);

l. maintaining a confidential primary case record for each individual served in accordance with established format (Chapter 1800);

m. coordinating and monitoring to ensure that individuals who need guardianship, conservatorship, a surrogate parent, an authorized representative for ALTCS, or a Representative Payee are referred for this assistance and representation (Chapter 1900);

n. ensuring individuals served are free from abuse and neglect, reporting suspected abuse or neglect in accordance with specified procedures, and providing follow-up as necessary (Chapter 2000);

o. ensuring that unusual incidents are reported timely, appropriately, and completely and completing follow-up responsibilities if necessary (Chapter 2100);

p. providing written notice of intended action whenever eligibility is denied, services are changed or reduced, or services are terminated; providing notice of appeal rights; and participating in grievance and appeals processes as necessary (Chapter 2200);

q. reporting to contracting, certification, provider relations, and/or monitoring staff any suspected violations of contract, certification or monitoring/licensing requirements (Chapter 2300); and

r. entering required information into ASSISTS in an accurate and timely manner (Chapter 2500).

404 Assignment of Support Coordinators

Each person eligible to receive services from DES/DDD must have a Support Coordinator assigned. The Support Coordination Supervisor is responsible to ensure that the individual/family has the opportunity to choose a Support Coordinator and to ensure caseload assignments are made in a manner which will assure an equitable distribution of workload and as manageable a caseload size as possible, while minimizing frequent changes in the Support Coordinator assigned to a particular individual/family.

As part of the intake process, individuals/responsible persons will be informed of the option of choosing a Support Coordinator if a choice is available. Individuals who are currently eligible for services through DES/DDD will be informed of the option of choosing a Support Coordinator as part of the ISP process. The Supervisor will respond or make the requested change within 10 working days.

The Support Coordinator Supervisor will insure that individuals/responsible persons will be given an opportunity to meet with Support Coordinator(s) prior to making a choice. If the chosen Support Coordinator has a full caseload, the individual/responsible person will be able to meet with the Support Coordinator Supervisor to discuss needs and preferences. The Support Coordinator Supervisor will attempt to match the individual/responsible person with another Support Coordinator who has the skills and abilities the individual/responsible person desires. The individual/responsible person may also choose to be placed on a pending list for their first choice of Support Coordinator. If the individual/responsible person chooses placement on a pending list, another Support Coordinator will be assigned in the interim. Support Coordinator Supervisors will insure the individual/responsible person is placed with the Support Coordinator of choice whenever possible.

Each person eligible for ALTCS services must also have a designated back-up Support Coordinator. If an individual/responsible person/family member contacts an office and the assigned Support Coordinator is not available, the person should be referred immediately to the back-up Support Coordinator for assistance. In instances where a back-up Support Coordinator is not an option or is not available, the Support Coordination Supervisor will act as back-up.

All Support Coordinator assignments shall be identified in ASSISTS with the identification number of the responsible Support Coordinator. In the event of a position vacancy or a Support Coordinator on long term leave, the identification number of the back-up Support Coordinator or Support Coordination Supervisor who is actually responsible for the individual during the vacancy/leave is to be entered in ASSISTS in advance of the change.

Whenever a change in Support Coordinator assignment is made, the individual/responsible person must be notified of the change in writing in advance of the change. A Support Coordinator who is resigning is responsible for sending a letter informing the individual/responsible person of the resignation and advising of the back-up Support Coordinator who will be assigned during the vacancy. A newly hired Support Coordinator is also responsible for writing a letter of introduction to the individual/responsible person. Providers should also be notified of the new Support Coordinator.

405 Courtesy Support Coordination

Courtesy support coordination is defined as services provided to an individual/responsible person or family during a temporary absence from their area or district to another area or district of the state. Courtesy support coordination is provided by the receiving area or district before and during the temporary absence and will end once the individual returns to his/her home area or district.

The following guidelines are general in scope and each situation must be treated on a case by case basis to ensure, to the maximum extent possible, a continuity of supports and services in the new setting. If it becomes evident that the individual intends to remain in the new area or district, the courtesy status should end and the case transferred in accordance with Section 910 of the DES/DDD Policies and Procedures Manual.

As soon as the Support Coordinator in the home district becomes aware that the individual will be temporarily out of the area or district he/she will notify, in writing, his/her supervisor of the individual's intention to temporarily reside out of the area or district. The supervisor will transfer this information to his/her District Program Manager/Administrator (DPM/DPA) with a request assignment of a courtesy Support Coordinator in the receiving area/district. The DPM/DPA will transmit the notification to the receiving DPM/DPA. The notification will contain the following information:

a. individual's name, date of birth, documented disabilities, ASSISTS ID number and funding status (ALTCS or DD);

b. name(s) of family members who will be with the individual, responsible person, relationship to individual and their telephone numbers;

c. address (including ZIP code) of temporary residence (if known);

d. planned date of move and anticipated length of stay;

e. reason(s) for move (if known); and

f. name, telephone number and site code of the current Support Coordinator.

The DPM/DPA in the receiving district will transfer the notification to the appropriate supervisor for assignment of a courtesy Support Coordinator. The supervisor will assign a Support Coordinator in accordance with Section 404 of the DES/DDD Policies and Procedures Manual. The sending Support Coordinator is then notified of the name, telephone number and site code of the courtesy Support Coordinator.

The sending Support Coordinator and the courtesy Support Coordinator will discuss issues and make decisions regarding the responsibilities of both Support Coordinators including who will schedule and facilitate the annual ISP including the Individual Spending Plan and information as to income, benefits and any billing information (if applicable); who will review the ISP and effect needed changes and who will send copies to the team members. Additionally, a determination must be made as to whom will assure accuracy of all ASSISTS information. In all cases, the courtesy Support Coordinator will send copies of all documentation to the sending Support Coordinator. The Support Coordinator "closest" to the situation will write incident and unusual incident reports.

In complex situations, it may be necessary to address the following, in writing:

a. ALTCS/health plan notifications and enrollments;

b. primary care physician identification and therapist/specialist referrals;

c. school enrollment and outstanding educational issues;

d. DME/adaptive equipment;

e. service needs and referrals to new providers;

f. program Review Committee and Human Rights Committee involvement;

g. funding issues such as billing, billing waivers and Individual Spending Plans, etc;

h. behavioral health needs;

i. notification to Managed Care for individuals using a ventilator; monthly visit requirements, etc.;

j. anticipated visits by family, friends, etc.; and

k. contacts and follow-ups on individuals receiving Targeted Support Coordination.

Once the individual returns to his/her home area, the sending Support Coordinator will assume all responsibilities.

405.1 Courtesy Support Coordination for Foster Care

Courtesy Support Coordination may be provided for foster care cases when a child and/or family lives in one district and the legal responsibility for the case remains with another district. When the child is placed in another district for adoption, legal responsibility shall remain in the sending district. In most cases, the district with legal responsibility remains responsible for payment of services.

With the exception of adoption cases, case transfer may occur when the child and family have lived in the new district for three months or longer or if the child and family live in different districts and there are no plans to reunite the family.

The Support Coordinator in the receiving district shall be considered to be a service team member and shall participate in case plan staffings and case conferences.

In foster care cases, the request for courtesy support coordination shall include:

a. copies of relevant case information, including, but not limited to physical and psychological evaluations, provider reports, case planning documents, etc.;

b. the most critical factors concerning the child or family;

c. supervision services requested; and

d. other services the child and/or family are to receive.

A case conference, in person or by conference call, must be held within 15 working days after the receiving district accepts the case for courtesy supervision or transfer.

The Support Coordinator from the receiving district shall provide to the sending Support Coordinator, in addition to DES/DDD ISP responsibilities:

a. dates and types of contact;

b. progress towards the case goal;

c. changes in family functioning; and

d. review of the case plan and recommendation for any changes in goals, tasks or services.

406 Contracted Support Coordination

Support Coordination functions will not be included in provider contracts except on reservation and for early intervention. If unable to provide

Support Coordination on reservation through DES/DDD staff positions, the function may be provided through a contracted position subject to authorization by the Administrator of Business Operations. Contracted Support Coordinators must receive the same training as DES/DDD Support Coordinators.

407 Targeted Support Coordination

Targeted Case Management is an optional service under the Medicaid State Plan. The Health Care Financing Administration (HCFA) approved the Arizona request to provide Targeted Case Management (known in DES/DDD as Targeted Support Coordination - TSC) to certain individuals with developmental disabilities effective 10/1/96.

TSC provides for support coordination for individuals who are eligible for Medicaid but not eligible for ALTCS. TSC allows the individual/responsible person to determine how much Support Coordination they want or need. This program does not provide for the other services covered by ALTCS such as respite, habilitation, etc. Appendix 400.A provides visual details about TSC. The Support Coordinator will assist with access to community services including the AHCCCS Health Plan used by the individual.

407.1 Guidelines for Targeted Support Coordination

The criteria for TSC includes individuals not eligible for ALTCS, but enrolled in AHCCCS by receiving Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF) and/or other means.

a. Support Coordinators will assist in identifying TSC eligible individuals by obtaining AHCCCS, TANF and SSI information on individuals eligible for services from DES/DDD. Eligibility for TANF or SSI shall be noted "Y" in the appropriate field on the ASSISTS Benefits and Evaluation Screen. If the individual is AHCCCS eligible, this must be noted with "ZA" on the Billing and Financial Screen in ASSISTS. If the individual's name is not on the AHCCCS TSC list (received monthly by Support Coordinators) and the Support Coordinator knows the individual is receiving AHCCCS, the District ALTCS Specialist shall be notified;

b. Support Coordinators shall contact all individuals/responsible persons identified as meeting TSC criteria. Contact may be by letter (Appendix 400.B), telephone or in person to identify and document the type and frequency of contact the person desires;

c. an annual Individual Support Plan (ISP) is required for all TSC eligible individuals. The plan should be very flexible and document what makes sense for the individual. At a minimum, the plan will need to document the type and frequency of support coordinator contact the person desires. This may be done by attaching the returned contact letter (if a letter was sent) to an ISP Cover Sheet (DD-214 - Appendix 800.A) and placing both in the ISP section of the file (if the person does not want to meet). If the individual is choosing to hold the ISP over the phone (this is only acceptable if they have no other DES/DDD funded services), the Support Coordinator would fill out the Cover Sheet (DD-214 - Appendix 800.A), write a narrative and send both to the individual/responsible person for signature within 15 working days of the phone conversation. The Support Coordinator would keep copies of the ISP and document in the progress notes that it was sent for signature. For face-to-face meetings, the Support Coordinator will follow DES/DDD Policy related to ISPs keeping the plan flexible, documenting what makes sense for the individual;

d. for newly DES/DDD eligible individuals showing on the AHCCCS TSC list, the Support Coordinator will meet with the individual/responsible person within 12 working days of TSC identification to develop the annual ISP. The ISP may be a Cover Sheet (DD-214 - Appendix 800.A) and a narrative. To fully introduce the individual/responsible person to the service systems he/she may want to access, the Support Coordinator will review the plan with the individual/responsible person every 90 days for the first six (6) months. Thereafter, the individual/responsible person will determine the type and frequency of on-going contact he/she desires except as noted in 407.1.g;

e. for individuals currently DES/DDD eligible, identified as eligible for TSC and contact was made by letter:

1. the Support Coordinator will deliver the TSC service as identified in the returned letter or if case closure was requested, follow the procedures in Chapter 1100 of the DES/DDD Policy and Procedures Manual;

2. if there is no response to the letter, the Support Coordinator will attempt to contact the individual/responsible person by phone or in person and provide TSC as requested;

3. if the Support Coordinator is unable to contact the individual/responsible person by phone or in person, another TSC letter will be sent via certified mail, return receipt requested. The Support Coordinator will document the attempts to contact the individual/responsible person and continue to provide service as documented in the last ISP until contact is made or discharge procedures need to be implemented (see Chapter 1100 of this Manual); or

4. if the individual/responsible person does not want the TSC service but does want to maintain DES/DDD eligibility, the procedures regarding "inactive status" as noted in Administrative Directive #32 will be followed. If the individual/responsible person wishes to reactivate any kind of contact, the Support Coordinator will the individual is added back to the TSC list and will update ASSISTS accordingly.

f. the level of TSC will be adjusted anytime the individual/responsible person desires and the Support Coordinator will document the change in the ISP section of the file and provide the type and frequency of Support Coordinator indicated;

g. the following circumstances require contact as established in Chapter 1000 of this Manual or more frequent contacts as requested by the individual/responsible person when DES/DDD funds are used to pay for the service:

1. the individual is newly DES/DDD and TSC eligible;

2. the individual is AzEIP eligible;

3. the individual resides in a Group Home, Adult Developmental Home or Child Developmental Foster Home; or

4. the individual receives Attendant Care provided by a family member.

h. monitoring will be done by random quarterly reviews of case files using the TSC Audit Tool (Appendix 400.A). The TSC Audit Tool will monitor documentation of type, frequency, delivery and satisfaction with Support Coordination services.

i. it is important that Support Coordinators remain cognizant of the DES/DDD Mission and of the Family Support Principles when delivering TSC. Even though there are limited funds for services, there is much a Support Coordinator may do to assist an individual in accessing the supports he/she might need from their community. Support Coordinators may assist individuals in gaining access to needed medical, social, educational and other support services that may consist of the following:

1. informing individuals of options including medical services available from AHCCCS Health Plans based upon assessed needs;

2. coordinating and participating in the ISP meetings including developing, revising and monitoring the ISP;

3. locating, coordinating and arranging social, educational and other resources to meet the individual's needs;

4. providing necessary information to providers about any changes in the individual's functioning to assist the provider in planning, delivering and monitoring services; or

5. informing family members or other caregivers of the support needed to obtain optimal benefits from available services.

j. Support Coordination, in the context of Family Support, consists of activities designed to:

1. strengthen the role of the family as primary caregivers, thereby reducing dependency upon government support;

2. prevent costly, inappropriate and unwanted out-of-home placements and maintain family unity;

3. reunite families with children with disabilities who have been placed in government funded out-of-home placements, whenever possible; and

4. identify services provided by other agencies to eliminate costly duplication.